

Emergency Preparedness Regional Roles and Contact Information

Geographic regions have been established for preparedness for bioterrorism (BT) and other public health emergencies. Regional health educators, coordinators, and hospital planners have been hired to assist communities in planning for infectious disease emergencies, as well as other biological, chemical, or nuclear events that may threaten Massachusetts citizens. The Massachusetts Department of Public Health (MDPH) Center for Emergency Preparedness was created to coordinate emergency planning and response activities across the state.

Emergency Preparedness Regions. In 2002, seven bioterrorism preparedness regions were created to include all the communities in Massachusetts (see map). Each region has a health educator and a coordinator, and the hospital planner works with all seven regions. The roles are described in general terms below:

Regional Health Educator: Regional health educators are responsible for education and training activities regarding surveillance, reporting and control of infectious diseases and working with local boards of health, hospitals, regional coordinators, and other partners to improve emergency preparedness in the region.

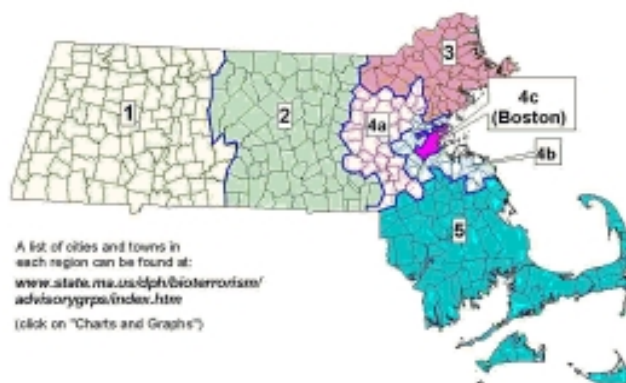
Regional Coordinator: Regional coordinators work with local partners to develop emergency preparedness plans, including local and regional policies and protocols. Partners include local boards of health, hospitals, public safety, regional health educators, the regional hospital planner, and other entities.

Regional Hospital Planner: The hospital planner will be hired to work with regional hospital liaisons, regional coordinators, and regional health educators to develop hospital emergency plans in each region.

The activities of the coordinators, hospital planner, and health educators are integrated; the individuals filling these roles collaborate closely together and with community agencies to improve emergency preparedness.

Please feel free to contact the individuals listed to the right to discuss emergency preparedness in your town, city, hospital or region.

Emergency Preparedness Regions



Region	Regional Health Educator	Regional Coordinator
Region 1 Western	Barbara Coughlin Email: barbara.coughlin@state.ma.us Phone: (413) 586-7525	Don Snyder Email: donald.snyder@state.ma.us Phone: (413) 586-7525
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Region 4a Metro-West	Judith Chevarley Email: judith.chevarley@state.ma.us Phone: (617) 983-6800	Beverly Anderson Email: beverly.anderson@state.ma.us Phone: (781) 828-1310
Region 4b Metro-Boston	Rachel Heckscher Email: rachel.heckscher@state.ma.us Phone: (617) 983-6800	Mary Clark* Email: mclark@challiance.org Phone: (617) 665-3688
Region 4c Boston	Brad Cohen* Email: delvalle@bostonems.org Phone: (617) 343-1370	Suzanne Strickland* Email: sstrickland@bphc.org Phone: (617) 534-5678
Region 5 Southeast	Lisa Crowner Email: lisa.crowner@state.ma.us Phone: (508) 977-3000	Diane Brown-Couture Email: diane.brown-couture@state.ma.us Phone: (508) 977-3000
All health educators and coordinators are MDPH employees except those denoted with an asterisk (*).		



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Epidemiology

Active Surveillance –What is it?

Timely identification and reporting of infectious diseases is necessary to implement appropriate control measures effectively and prevent illness. To that end, in the fall of 2001, the Massachusetts Department of Public Health (MDPH) initiated a state-wide laboratory-based active surveillance project to monitor for seventeen organisms (see box).

The goals of the active surveillance project are to ensure timely identification of bioterrorism events, foodborne and waterborne outbreaks and emerging infectious diseases; and to monitor antimicrobial resistance patterns. To date, 52 hospital laboratories are reporting directly to MDPH on a regular basis as part of active surveillance project.

Passive surveillance is a traditional reporting mechanism whereby MDPH receives data relevant to a reportable infectious disease without the epidemiologists' intervention. Once the report is received, additional information is collected and follow-up activities begin.

Active surveillance differs from passive surveillance in that MDPH is directly collecting information from hospital laboratories. MDPH epidemiologists worked with hospital laboratory and infection control staff to establish formal reporting mechanisms. When data are not received, follow-up is initiated.

Increased electronic laboratory reporting is a long-term goal, but has been established in several instances. Since January 2002, Quest Diagnostics has reported all reportable laboratory results electronically. Recently, UMass Memorial Medical Center, which performs laboratory testing for three campuses in Worcester, and for its partners Clinton Hospital and UMass Marlborough Hospital, began reporting serology, microbiology and antibiotic susceptibility data to MDPH. MDPH receives data through secure data transmission. The data are reviewed and entered into the statewide surveillance system. This process has significantly reduced paperwork and manual data entry for Quest, UMass and MDPH, and allows MDPH to report to local boards of health in a timely manner.

Through this active surveillance initiative, MDPH expects to increase the timely notification of reportable conditions, track

emerging pathogens and monitor antimicrobial resistance trends. These efforts will assist MDPH in its mission of reducing infectious disease morbidity and mortality throughout the Commonwealth.

Active Surveillance Organisms

Bacillus anthracis
Brucella species
Cryptosporidium species
E. Coli O157:H7
Francisella tularensis
Giardia lamblia
Invasive Group A *Streptococcus*
Invasive Group B *Streptococcus*
Haemophilus influenzae
Listeria monocytogenes
Methicillin-resistant *Staphylococcus aureus* (MRSA)
Neisseria meningitidis
Salmonella species
Shigella species
Streptococcus pneumoniae
Vancomycin-resistant enterococci
Yersinia pestis



Save The Dates!

Mass Vaccination Clinics: A Reality Check - March 18, 2004 from noon to 1:30. A live satellite broadcast at the State Lab Institute 305 Sout Street, Jamaica Plain, MA. Contact Michael Pierce at (617) 983-6886 for additional sites. 1.5 CEUs will be offered. For more information visit <http://www.cklhn.com/create_frameset.cfm?id=2&CFID=14903&CFTOKEN=53595852>

Massachusetts Adult Immunization Conference
April 13, 2004 from 9:00 to 3:00 at the Worcester Centrum, Worcester, MA. Registration fee is \$35.00. Contact Monique Cassidy from MassPRO at (781) 419-2741 or visit www.mapro.org for more information on the conference. CEUs will be available.

Local Planning for Emergency Clinics

The recent experience in Pittsburgh, where 8,500 people required immune globulin following an outbreak of hepatitis A, demonstrated the importance of communities being prepared to quickly implement emergency clinics. In any infectious disease emergency, whether natural or manmade, local communities will need to implement *Emergency Dispensing Sites*, clinics to administer vaccine or dispense medication, for the population in their jurisdiction.

The Emergency Dispensing Site Work Group, a subgroup of the Strategic National Stockpile (SNS) Work Group, is developing a planning template to assist communities in planning and implementing emergency clinics. The template is based on the worst-case scenario in which 80% of the population in any jurisdiction would need to be vaccinated or receive medication in 3 days, with the remaining 20% processed over the subsequent 3 days. Major components of emergency dispensing site plan include establishing a planning team, identifying clinic sites and recruiting volunteers to staff the clinics.

Local health departments will be notified of the availability of the planning template on the MDPH website, expected by February 2004. For more information, contact Robert Paone, State-wide SNS Coordinator, at 508-820-2011, or Donna Lazorik, Adult Immunization Coordinator, at 617-983-6821.



Flu Event Stresses the Importance of Vaccination

Health officials gathered at the Statehouse on October 29 to stress the importance of getting immunized against the flu.

Speakers included Dr. Jennifer Davis Carey, secretary of the Executive Office of Elder Affairs; Dr. Alfred DeMaria Jr., assistant commissioner of the Massachusetts Department of Public Health; Dr. Marylou Buyse, president of the Massachusetts Association of Health Plans; and Patrick O'Reilly, assistant director of education and evaluation for MassPRO.

The event and speakers emphasized that a great deal of illness can be prevented with a flu shot and that while the best time to get flu vaccine is in October or November, getting vaccinated in December or later can still protect against the flu. In New England, flu season typically begins in December and lasts through March.

During the event, Massachusetts Immunization Program nurses also conducted a flu clinic in the Nurses' Hall and vaccinated 132 Statehouse employees, officials and legislators, as well as Drs. Carey and DeMaria.

Each year in Massachusetts, an estimated 850 residents die from flu-related complications and another 2,600 are hospitalized.

Flu vaccine is strongly recommended for people over 65 years old; those with chronic health conditions, such as diabetes, asthma, HIV/AIDS, kidney disease and cardiovascular diseases; pregnant women who are more than three months pregnant during flu season; people in nursing homes or chronic care facilities; health care workers; children and adolescents receiving long-term aspirin therapy; and household contacts of those at high risk.

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Christine C. Ferguson, Commissioner of Public Health

Current and past issues of CD Update are available online at:
<http://www.state.ma.us/dph/cdc/update/comnews.htm>

Contact Jacqueline Dooley at jacqueline.dooley@state.ma.us or (617) 983-6559 to have PDF versions emailed or faxed to you

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You Be The Epi

You Be the Epi - Chickenpox:

A school nurse calls the Division of Epidemiology and Immunization. It seems they have a 5th grade student who developed chickenpox yesterday and the school is looking for guidance regarding what they should do.

You ask the school nurse a few questions to help determine who was exposed to this student. Using this information, it is determined that the 25 children in the case's class, as well as his teacher and the teacher's aide are all considered contacts. Further investigation reveals child walks to school with his sister (who is a 3rd grade student and has been vaccinated), eats lunch with the same 25 classmates and does not participate in any extracurricular activities. Therefore, no additional contacts have been identified. Now, she will need to assess each contact for their susceptibility to varicella. The Massachusetts Immunization Program (MIP) has provided a letter for the school to send to those exposed, indicating the appropriate steps to take. This includes providing the school nurse with written documentation of immunity. Acceptable documentation for the students includes any of the following: 1) a physician-certified history of disease, 2) documentation of prior vaccination against chickenpox, or 3) serologic proof of immunity. For exposed staff, they may self-report a history of disease, in addition to meeting any of the other criteria mentioned above. In addition, those who are susceptible and can be vaccinated for chickenpox within 3 to 5 days from their last exposure will not be excluded if they provide the school nurse with the documentation of this vaccination. In this particular setting, no high risk individuals have been identified and therefore, the school will allow susceptible children to be vaccinated within 5 days from their last exposure and still not be excluded.

Using the above criteria, the school nurse identified 4 susceptible children in the class, and because of the rapid notification about the case, there was sufficient time for 3 of them to be vaccinated post exposure and not be excluded. The 4th susceptible contact has a religious exemption and neither a history of disease nor laboratory evidence of immunity, and does not wish to be vaccinated. Therefore, as with any other children or staff member who is still susceptible, he will be excluded from day 10 through day 21 from his last exposure, per the Isolation and Quarantine Requirements, 105 CMR 300.000 (revised as of February 2003). The school entry requirement for varicella, which is being phased in and will include childcare, preschool, and grades K-12 by 2005, is not in effect for this grade for this year. However, this does not affect the exclusion criteria and all contacts should be dealt with as outlined above. Many may have had disease and therefore are not susceptible; yet, the school nurse needs documentation. Lastly, the exposed staff have all reported reliable histories of disease, so there is no exclusion.

In the near future, the school nurse and local board of health

plan to work together, sending a letter requesting that parents in the other 5th grade classes voluntarily provide documentation if their child is immune to varicella. It will be requested of staff at the school as well. This information will be helpful if another case occurs, and will mean less work on short notice for parents, staff, the local board of health and the school nurse!

Save the Date

Isolation and Quarantine:

A Massachusetts Satellite Training Broadcast
Wednesday, March 30, 2004

12:30 - 3:30pm

Sponsored by the Massachusetts Department of Public Health (MDPH)
and the

Harvard School of Public Health Center for Public Health Preparedness

PURPOSE:

To prepare participants to respond to infectious disease cases and emergencies by understanding, implementing, and enforcing isolation and quarantine measures.

THESE QUESTIONS AND MORE WILL BE ANSWERED DURING THE BROADCAST:

- What do isolation and quarantine mean?
- When are isolation and quarantine used?
- What happens when someone refuses a quarantine?
- Can police detain someone who is quarantined?
- What is the role of local health in isolation and quarantine?

FACILITATED SITES:

This broadcast will be downlinked at approximately 15 facilitated sites in Massachusetts.

TARGET AUDIENCE:

Local health department employees and board of health members; public safety professionals; hospital staff and administrators; community healthcare providers; municipal, public health and other attorneys; mental health and substance abuse providers; and school nurses, physicians and administrators.

The broadcast is free, but preregistration is required.
Registration has begun.

More information is available on the MDPH web site at:
www.mass.gov/dph/broadcast/

HIV/AIDS Surveillance

Focus on MPPG priority populations for HIV prevention in Massachusetts

The **Massachusetts HIV Prevention Planning Group (MPPG)** is a statewide advisory committee comprised of a diverse group of community representatives providing consultation to the HIV/AIDS Bureau of the Massachusetts Department of Public Health (MDPH). The MPPG prioritizes groups (or subpopulations) based on information derived from an analysis of HIV/AIDS case reports received by the HIV/AIDS Surveillance Program and from other sources. In the past, priority subpopulations have included groups that comprised the larger numbers of persons with HIV infection and/or AIDS and groups at increased risk for HIV/AIDS (i.e. – incarcerated, refugees and immigrants, communities of color, women, and adolescents).

In 2003, the MPPG reached consensus to recommend prioritization based on mode of HIV transmission. The three priority populations are men who have sex with men (MSM), injection drug users (IDU) and heterosexuals. The table presents a profile of HIV infection and AIDS among these groups and trends.

- As of December 1, 2003, there were a total of 14,562 people living with HIV/AIDS in Massachusetts. Of these, the reported mode of transmission was: MSM in 33%, IDU in 31%, Heterosexuals in 14%, MSM/IDU in 3%, receipt of blood/blood products in 1%, and no identified risk in 18%.
- Although women comprise only 32% of cases in the IDU risk group, they comprise 70% of cases in the heterosexual risk group.
- Over the last ten years, AIDS cases have declined by 77% both in MSM and IDUs, and by 43% among those with reported heterosexual risk.
- Over the last four years, among HIV cases, there have been only marginal declines in number of HIV cases diagnosed among MSM and those with reported heterosexual risk, while more substantial declines have been observed in the number of HIV cases diagnosed among IDUs.
- Among those with HIV infection, the proportion of cases among IDUs has declined over the last four years, while the proportion among both MSM and those with reported heterosexual risk has increased.

The HIV/AIDS epidemic in Massachusetts is complex and requires an understanding of trends within individual risk groups. The patient information collected and analyzed from case report forms can help guide prevention efforts and inform decisions regarding the allocation of resources.

<i>Demographic Profile of Prevalent HIV/AIDS Cases Among MPPG Priority Populations</i>						
	MSM		IDU		Heterosexual	
	#	%	#	%	#	%
Gender						
Male	4,743	100	3,017	68	610	31
Female	0	0	1,438	32	1,387	100
	4,743	100	4,455	100	1,997	100
Race/Ethnicity	#	%	#	%	#	%
White	3,584	76	1,716	39	513	26
Black	536	11	1,063	24	726	36
Hispanic	525	11	1,645	37	717	36
Asian	65	1	8	0	23	1
American Indian/Alaskan	5	0	7	0	3	0
Unknown	28	1	16	0	15	1
	4,743	100	4,455	100	1,997	100
Age In Years at AIDS Diagnosis (for AIDS Cases)						
	#	%	#	%	#	%
0-12	0	0	0	0	0	0
13-19	7	0	6	0	8	1
20-29	358	15	302	11	213	19
30-39	1,188	48	1,360	50	526	46
40-49	697	28	922	34	275	24
50+	201	8	140	5	118	10
	2,451	100	2,730	100	1,140	100
Age At HIV Diagnosis (for those with HIV infection, but not AIDS)						
	n/a	n/a	n/a	n/a	n/a	n/a
0-12	n/a	n/a	n/a	n/a	n/a	n/a
13-19	45	2	18	1	37	4
20-29	594	26	391	23	273	32
30-39	1,097	48	819	47	340	40
40-49	438	19	434	25	152	18
50+	118	5	63	4	55	6
	2,292	100	1,725	100	857	100
Year of AIDS Diagnosis						
1993	624	42	707	47	170	11
1994	475	38	576	46	199	16
1995	433	37	579	49	166	14
1996	352	36	440	46	174	18
1997	243	33	360	50	123	17
1998	254	36	339	47	121	17
1999	224	32	363	52	112	16
2000	163	30	260	47	128	23
2001	160	35	199	43	102	22
2002	142	35	165	41	97	24
Year of HIV Diagnosis						
1999	208	43	181	37	95	20
2000	221	52	114	27	93	22
2001	176	52	96	28	67	20
2002	203	53	93	24	89	23

Quinolone resistant *Neisseria gonorrhoeae* continues to rise in Massachusetts

Over the last two years, Massachusetts has experienced an increase in the number of cases of quinolone resistant *Neisseria gonorrhoeae* (QRNG). Between January 1 and November 30 2003, a total of 49 cases have been identified, compared to 10 cases in 2002. The occurrence of QRNG has also increased more rapidly in last three months: half of all cases since January 2003 were identified since September. Year-to-date, 13% of all gonococcal isolates identified at the State Laboratory Institute are resistant to quinolones.

Of the 49 cases so far in 2003, 47(96%) were among men, and 43 (92%) of these cases were identified among men who have sex with men (MSM). Only 23% of the cases were diagnosed in the state funded STD clinics. Travel abroad (Guatemala and the Philippines) was reported by cases in women and in half of men reporting sex exclusively with women. Four other patients (MSM) reported travel to Germany, New York, Chicago, San Francisco and Maine. An analysis of the data available through August 31, 2003 demonstrated that, in the STD clinics, the proportion of quinolone resistant strains was 1.8% among men reporting sex exclusively with women and 11.1% among MSM. There were no cases of QRNG identified in females in the STD clinics.

It is difficult to assess the extent of drug resistant gonorrhea in the state because most clinicians do not use culture to diagnose gonorrhea. It may be more prevalent than current estimate. The Division of STD Prevention has sent a clinical advisory to alert clinicians that it no longer recommends the use of quinolones for the presumptive treatment for gonorrhea or treatment based on a non-culture test result. Ceftriaxone (Rocephin®) 250 mg IM remains the preferred regimen for the treatment of uncomplicated gonococcal infections. Ceftriaxone is effective against infection at all anatomical sites, is safe to use during pregnancy and in adolescents. Furthermore, if a case of gonorrhea treated with a quinolone is reported to us, we advise the health care provider that a test of cure be performed at all involved sites if culture was not initially used to rule out resistance.

Resistance to cephalosporins has not been reported. However, any time gonorrhea symptoms do not resolve, be sure to order a culture so that antibiotic susceptibility testing can be performed. The STD Laboratory of the Massachusetts Department of Public Health will provide technical guidance and testing services. You can contact the STD Laboratory at 617-983-6600.

Clinical consultation, practice guidelines and epidemiological services are available through the STD Division. Please call for any assistance at (617) 983-6940.

The STD/HIV Prevention Training Center of New England: 2003 Highlights

The STD/HIV Prevention Training Center (PTC) of New England is one of ten national sites funded by the CDC to provide clinical training for healthcare providers in the diagnosis, treatment and management of sexually transmitted diseases and the prevention of HIV infection. Clinical training courses are offered to providers throughout New England. Since 1995, the PTC has trained thousands of health care professionals through self-study materials, intensive multi-day courses, laboratory courses, grand rounds, and other specialized on-site lectures. A program of the MDPH Division of STD Prevention, our partners in training are the State Laboratory Institute, Massachusetts General Hospital, Boston Medical Center, Connecticut State Laboratory, City of Hartford Health Department, and the National Laboratory Training Network.

The PTC is part of the National Network of Prevention Training Centers (NNPTC), which works collaboratively to develop and deliver innovative STD/HIV training to practitioners. In 2003, NNPTC produced an on-line STD case series that offers free continuing education credits to providers. Each case includes a visually engaging, interactive patient presentation, which simulates an actual clinic encounter. Users are asked to take a sexual history, conduct a physical exam, order diagnostic tests, decide on treatment for the patient and partner(s) and provide counseling on risk reduction and prevention strategies. Visit the NNPTC website or www.stdcases.org to access this series.

Another recent effort of the PTC, in conjunction with other PTCs in the Eastern geographic region of the U.S., was the development of a training curriculum, entitled "Prevention and Management of STDs in Persons Living with HIV/AIDS". This comprehensive curriculum addresses the clinical, behavioral counseling, and partner management issues related to STDs in persons living with HIV/AIDS. In partnership with New England AIDS Education and Training Center, we have begun to disseminate this important information to HIV care providers throughout New England.

For more information on courses and educational resources, contact Janine Walker Dyer at 617-983-6964 or visit the website of the National Network of Prevention Training Centers at www.stdhivpreventiontraining.org.

Save the date!! A half-day STD update conference will be held April 15, 2004. More information coming soon!

Refugee and Immigrant Health

Resettlement of Liberian Refugees

Approximately 8,000 Liberian refugees will be resettled in the U.S. by the end of the current fiscal year. Most fled Liberia in the early 1990's and found relative safety in Ivory Coast until September 2002. At that time, an armed uprising in Ivory Coast led to a humanitarian crisis. Liberians were attacked and atrocities were committed against them; others were forced out of the region. Refugees, including children, were forcibly recruited into armed groups. Many fled back to Liberia, into an area of intense fighting in the Liberian civil war.

The United Nations High Commission for Refugees (UNHCR) evacuated refugees to newly established transit centers and camps. UNHCR sought, unsuccessfully, to identify a third country in the region that could accept Liberian refugees. In May 2003, the U.S. initiated plans to resettle the refugees in the U.S. through a 'fast track' program. Nearly 900 refugees arrived before September 30, 2003. The remainder is expected to arrive this year.

Over 70% of the population are women and children; the majority either ethnic Krahn or Grebo. Fragile family structures such as single parents with several small children, disabled adults, multigenerational households, and adopted children, resulted from the loss and separation that occurred either in the early flight from Liberia or the more recent conflict and targeting of Liberians.

As is the case with all refugees, Liberians will complete a medical examination prior to departure for the U.S. The International Organization for Migration (IOM) is responsible for the medical exams, in coordination with the Centers for Disease Control and Prevention (CDC). Preliminary data are available from the first group of approximately 2,000 screened. The rate of smear positive tuberculosis (TB) was over 350 per 100,000. All individuals with active TB are being treated with standard regimens given by directly observed therapy (DOT).

The IOM also reported outbreaks of suspected measles and varicella in the transit centers and camps. In response, IOM and CDC implemented active surveillance for febrile rash illness, monovalent measles vaccination, and holds on movement to the U.S. from camps with suspected disease. Varicella vaccine is not available in Ivory Coast. With these interventions in place, recent cases of varicella among Liberian refugees have not been reported. Refugees should have vaccination records, either from IOM or the UN or both that will facilitate bringing them up-to-date by U.S. and Massachusetts guidelines. Because of the overseas vaccination campaigns, tuberculin skin testing should be delayed until 4-6 weeks after the last live viral vaccine was given.

Refugees coming to the Massachusetts will undergo full medi-

cal evaluation shortly after arrival through the Refugee Health Assessment Program. The infectious disease issues should be viewed in the context of the broader health and psychosocial issues facing the Liberians. Malnutrition and impaired immune system function may contribute to increased susceptibility to infections. In addition, malnutrition and psychological trauma or deprivation may cause other problems such as anemia and abnormal child growth and development as well as symptoms of psychological distress.

Sources: Office of Global Health Affairs, HHS; Division of Global Migration and Quarantine, CDC; Bureau of Population, Refugees and Migration, Department of State; Amnesty International.

FY04 Refugee Admissions

President George W. Bush signed the Presidential Determination on FY 2004 Refugee Admissions to the United States on October 21, 2003. Although a total of 70,000 admissions were authorized, 20,000 were in the "unallocated reserve" category. These reserve admissions have not been used in recent years, leaving the projected ceiling for admissions at 50,000. The FY04 allocations by region, as well as the FY03 allocations and admissions, are summarized in the following table.

<i>Region</i>	<i>FY03 Regional Ceiling</i>	<i>Total Arrivals In FY03</i>	<i>FY04 Regional Ceiling</i>
Africa	20,000	10,717	25,000
East Asia	4,000	1,724	6,500
Europe/Central Asia	16,500	11,269	13,000
Latin America/Caribbean	2,500	452	3,500
Near East/South Asia	7,000	4,293	2,000
Unallocated Reserve	20,000	0	20,000
Total	70,000	28,455	70,000



Guide for the Treatment and Detection of TB In College and University Students

In August, the Medical Advisory Committee for the Elimination of Tuberculosis (MACET) and its College Health Subcommittee published a guide for college and university health services entitled *Detection and Treatment of Latent Tuberculosis Infection in Massachusetts College and University Students*. With college and university students making up approximately 4% of the Commonwealth's tuberculosis case burden in one recent 5 year period, the development of the Guide was undertaken in response to requests from college health services for clarification and guidance in managing TB infection and disease.

Created by experts in tuberculosis, public health, and college health, the Guide provides *practical, step-by-step operational information* for college health professionals to help them design policies and protocols. There are four components of the MACET recommendations, and a chapter in the Guide is devoted to each. The components are:

1. The tuberculosis risk assessment,
2. Targeted testing for TB infection,
3. Performing the clinical evaluation on students found to be infected, and
4. Treatment of latent TB infection.

Each chapter, in turn, is divided into four sections: (a) scientific rationale, (b) operational guidance, (c) sample forms, and (d) program evaluation.

The Guide focuses on risk assessment and offers health providers detailed guidance on targeting testing for latent TB infection and treatment of persons found to be infected, based on risk. Recommendations follow current published guidelines of the American Thoracic Society, The Centers for Disease Control and Prevention, and the Infectious Diseases Society of America, and will be kept up to date by MACET and the TB Division, via the MDPH web site (www.state.ma.us/dph/cdc/tb/index.htm).

Publication of the Guide was a key feature of the *TB Seminar for College and University Health Services Personnel* held in Worcester on November 18, and attended by health professionals from across New England. The document is posted on the web site; it also can be obtained by calling the Division at 617-983-6970.

Nurse Highlight

This issue of communicable disease update will highlight Deborah McManus, RN, of the Lahey Clinic Medical Center.

Now in her 18th year with the Lahey Clinic Medical Center, Deborah McManus works in Pulmonary Care Medicine and cares for patients with lung disease. Although she has many other responsibilities at the clinic, Deb is referred to as the "TB Nurse". For the last five years she has been the Lahey Clinic TB Clinic Coordinator. The TB Clinic meets weekly, but Deb often sees TB patients during non-clinic hours to accommodate them. She states that, "It's worth doing some of the work on my own time to keep the TB Clinic at Lahey", and "I really enjoy the TB Clinic patients". Patients depend on the TB nurse and Deb is both an advocate and liaison for her patients. It is very time-consuming to collaborate and coordinate patient care with the different Board of Health nurses for the patients seen at Lahey TB Clinic, but Deb makes the best of the situation. It has been an eye opening experience for her. Being a 3rd generation Bostonian, she never realized the difficulties immigrants must overcome to become citizens of our country. She has also learned a lot about other cultures. Long after completing TB therapy, patients come back to visit her bringing pictures of their families and invitations to weddings, christening, etc.

When not working at Lahey Clinic Medical Center, Deb enjoys traveling and spending time with her 11-year-old daughter.

The Tuberculosis Division is pleased to recognize Deborah McManus for her dedication and commitment to TB Prevention and Control. We thank you Deb for all your hard work - Lahey Clinic Medical Center is fortunate to have you as part of their team.

Save the Date

Western Regional TB Conference for 2004. March 24, 2004 at the US Fish and Wildlife Service in Hadley, MA. The Bureau of Communicable Disease, Division of TB Prevention and Control, Massachusetts Department of Public Health is sponsoring a from 9:00 am to 12:15pm, with an afternoon workshop from 1:15pm to 3:15pm on Tuberculin Skin Testing.

This program is designed to maintain communication between our program staff and those who provide direct tuberculosis care. Several tuberculosis staff members will present current information on tuberculosis issues. Physicians, nurses, and other health care professionals, who are interested in diagnosing and treating TB, are welcome.

Please contact Evelyn Thomas at (413) 586-7525 for more information. **Preregistration is required.**